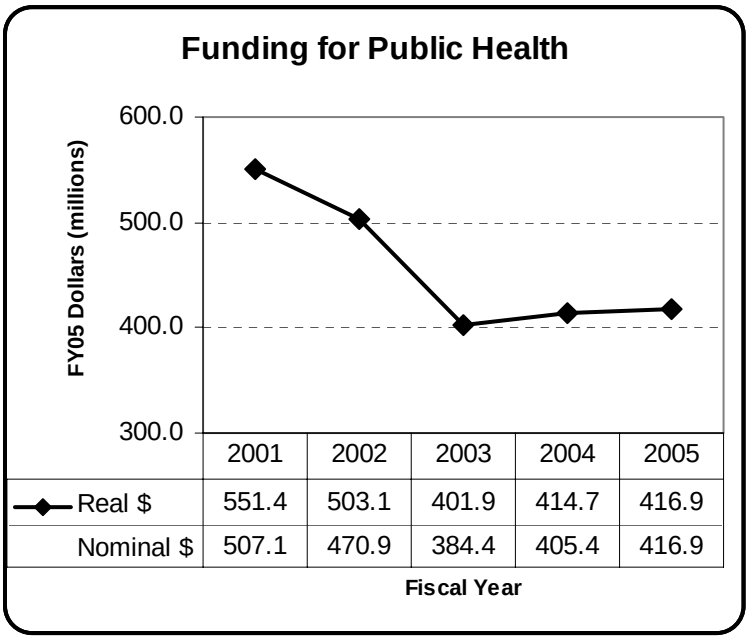
I. Safeguarding the Health of Women and Girls

Public health services play a critical role in improving and safeguarding the health and well-being of women and girls. There are public health programs that screen for certain diseases, others that prevent certain diseases from occurring, and those that provide access for vulnerable populations who are at risk for inadequate care.

Figure 39



Note: In order to facilitate year-to-year comparisons, these figures do not include funding for the Children's Medical Security Plan or the Healthy Start Program for which the Office of Medicaid shares responsibility. These figures do include the costs of the public health hospitals, and the costs of domestic violence programs which were moved to the Department of Social Services in fiscal year 2004.

The state has identified ten Leading Health Indicators recommended by the United States Health Service for monitoring state and local progress towards improving the Commonwealth's public health. Among these Leading Health Indicators are: access to health care, substance abuse and tobacco use, responsible sexual behavior, and injury and violence.

The dramatic reductions in overall public health funding have had an impact on the direct public health programming that had been successful in the past, and also have had a significant impact on the Commonwealth's ability to monitor the health status of women and girls since the fiscal crisis began. In real terms funding for public health programs dropped significantly between fiscal year 2001 and 2005, from $551 million in 2001 to $417 million in 2005 – a 24 percent reduction (see Figure 39).

One of the central functions of the Department of Public Health is the prevention of disease through the analysis of trends in illness across the Commonwealth, and in the monitoring health status. Unfortunately, the ability of the Department to track, monitor and evaluate trends has been severely affected by the reductions in funding for Department's operations.

For example, funding for at Health Statistics program within the Department was eliminated in Fiscal Year 2003. Funding for the Division of Health Care Quality stagnated during this period. Even within existing programs, the evaluation and analysis

functions within those programs were eroded as funding levels dropped. For example, within the state's smoking prevention efforts, research and evaluation of the program was funded at more than four million dollars in Fiscal Year 2000, but this funding was almost eliminated by Fiscal Year 2005.

As dollars for public health funding became scarce, administrators have concentrated remaining resources as much as possible in those areas that provide direct services to vulnerable people in the Commonwealth. As crucial as the direct service role of the Department of Public Health might be, reducing its role in planning, program development, health surveillance and evaluation also has significant consequences for the women and girls of the Commonwealth.

The Department of Public Health, in conjunction with local health departments, is the state's front line protecting the safety and integrity of the Commonwealth's water supply and food supply, and is the lead agency for protecting against and preventing outbreaks of infectious disease and epidemic. With lessened ability to monitor, evaluate, document and track unusual spikes or patterns in illness across the Commonwealth, the Department is constrained in its ability to prevent outbreaks of communicable disease.

As essential as the core functions of the Department of Public Health are to maintaining the health of the Commonwealth, there is also an important story in an analysis of several of the state's public health programs. This report looks at the Commonwealth's substance abuse programming, the smoking prevention programs, the Commonwealth's reproductive health programming, services for teenage parents, some of the efforts to protect women and girls from infectious disease, and services to address domestic violence.

These programs are not the only ones that suffered significant cuts during the state's fiscal crisis, but they serve as examples in which the cuts were significant and with dramatic and direct consequences for the health and well-being of women and girls. Furthermore, these particular programs also speak directly to the mission of the Department to measure its own success through the nation's identified Leading Health Indicators.

Preventing Substance Abuse

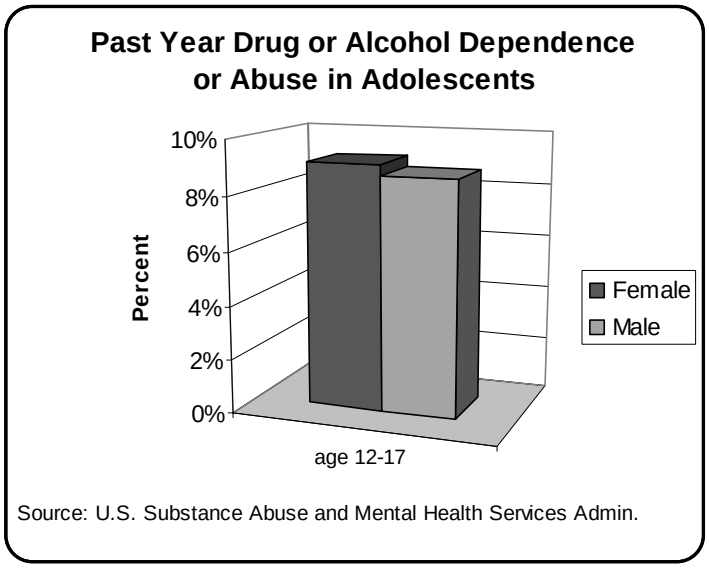
The abuse or misuse of alcohol and illegal substances, as well as the inappropriate use of legal substances such as inhalants or medications have an impact on both the long- and short-term health of people in the Commonwealth and are part of the challenges presented in the Leading Health Indicator of "substance abuse."

Impact on Women and Girls

Although for some women and girls substance abuse is connected to mental health or public safety concerns, the treatment of substance abuse remains a public health issue. There are a variety of substances subject to abuse, each of which presents different challenges in the areas of prevention and treatment. In addition to illegal substances such as marijuana, cocaine or heroin, the non-medical use of medications such as over-the-counter cold remedies or the abuse of prescription medications are of concern to health officials. Furthermore, the abuse of alcohol by adults and under-age drinking by girls and adolescents present their own set of challenges. Finally, the use of tobacco presents a significant public health issue that this report will address separately.

During the period 1999 to 2001, close to 6.5 percent of persons nation-wide age 12 and over reported the use of an illicit drug during the previous month. In this instance, "illicit drug" refers to marijuana/hashish, cocaine, inhalants, hallucinogens, heroin, or prescription-type medications used non-medically. During this same period, the rate for the greater metropolitan Boston area was 11.7 percent, with the rate for young adults (age 18 to 25) as high as 29 percent.[1]

Figure 40



Source: U.S. Substance Abuse and Mental Health Services Admin.

Substance abuse is an issue that particularly affects teenage girls. Although males have a higher rate of substance abuse than women in general, among adolescents there is almost no difference in the rates for boys and girls. According to a national survey in 2003, adult males (age 18 and over) were almost one-third more likely to be classified as having had illicit drug or alcohol dependence or abuse in the past year as were females. Just over 12.6 percent of adult males were substance and alcohol abusers, compared to 9.5 percent of women. For teenagers, however, the rate for boys and girls was essentially the same, with girls slightly higher than boys – 8.7 percent for boys and 9.1 percent for girls (see Figure 40).[2]

There have been a variety of estimates of the cost savings associated with the prevention of substance abuse. One study published by the National Institutes of Health estimated that for every dollar spent on substance abuse prevention, a community can save up to ten dollars in costs associated with counseling and treatment for drug abuse.[3] Furthermore,

while in 2000 the average cost of housing an inmate for one year in a facility run by the state Department of Correction was over $36,000, the cost of substance abuse treatment for one year ranged from $1,800 to under $7,000 per year.[4]

Appropriate substance abuse treatment can have a significant impact on the health of women and children. According to data from the Department of Public Health, in fiscal year 1999, there were 59 healthy babies born to the women in specialized residential settings for pregnant and postpartum women with substance abuse problems. Had these women remained untreated during pregnancy, the children would have been at risk for Fetal Alcohol Syndrome or fetal drug exposure. Children born with these conditions often require neonatal intensive care which could cost close to $66,000 per child, and are at risk for life-long learning and behavioral disabilities.[5]

Preventing substance abuse and providing treatment for persons addicted to or abusing substances is most successful when there is a comprehensive approach, using multiple strategies in a variety of settings. However, for treatment to be successful, individuals must remain in treatment for a sufficient period of time to allow them to learn to manage their addiction and to cope with the possibility of relapse. In most instances, people require approximately three months of treatment before they can make significant improvement.[6]

The Department of Public Health provides prevention services, residential treatment (short- and long-term), direct counseling and treatment on an outpatient basis, case management for individuals in recovery, services for the homeless, and services for people cited with first or second offenses of driving under the influence. Its short-term (less than 30 days) residential treatment programs provide medically monitored detoxification services for persons withdrawing from alcohol or other substances.

Several of the programs administered or funded by the Department of Public Health target the particular needs of women and girls. In particular, funding has supported long-term residential placements for pregnant and postpartum women that provide coordinated prenatal and pediatric care. There are also specialized residential services for women that allow women to receive treatment and maintain custody of their children, and specialized services for homeless families, providing shelter to families when the caretaking parent has a substance abuse problem. Homeless individuals and pregnant women are also among the high-risk populations given priority for short-term residential treatment.

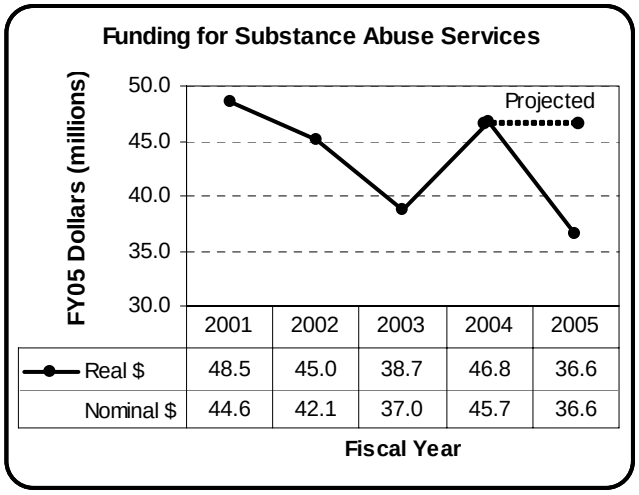
Clients of the Department of Public Health's Bureau of Substance Abuse Services are assessed a fee, based on their ability to pay. The Bureau pays for services for individuals who do not have coverage by private or public health insurance, and is the only payer for transitional support services. The Bureau is also the primary payer for residential rehabilitation services.[8]

Incarcerated women are a population particularly in need of substance abuse treatments. Although system-wide data are difficult to obtain, a survey of women incarcerated in western Massachusetts in the Hampden County Correctional Center found that between 75 and 90 percent of the inmates were addicted to substances, and 80 percent of their crimes were related to their addictions.[9] Not only is substance abuse treatment important during the period of incarceration and rehabilitation, there is need for continuing support upon release.

Funding

Funding for substance abuse services within the Commonwealth's budget was cut dramatically after fiscal year 2001 (see Figure 41). The Bureau of Substance Abuse Services within the Department of Public Health received $44.6 million in 2001, equivalent to $48.1 million in inflation-adjusted dollars. In just the one year between 2002 and 2003, the Bureau's annual budget was reduced by 14 percent in real terms. A supplemental budget passed at the end of fiscal year 2004 restored an additional $11.9 million dollars to that year's budget. This restoration, however, was on top of an original $3.9 million reduction in 2004, and reductions each of the prior years. Without this supplemental appropriation, the state would not have met certain federal guidelines for support for substance abuse services during the fiscal year, and federal dollars would have been lost. It is likely that state appropriations for substance abuse service funding will fall short of these guidelines once again in fiscal year 2005, necessitating a mid-year supplemental appropriation to ensure receipt of federal money. Even with these supplemental appropriations, however, services would be unlikely to return to their 2001 level.

Figure 41



Impact of Funding Cuts

The substantial cuts to substance abuse treatment programs in Massachusetts have had a dramatic impact on women struggling with substance abuse and addictions. Since the fiscal crisis beginning in fiscal year 2002, close to half of the state's residential treatment beds at detoxification facilities were shut down. Whereas the state previously funded 997 beds, there are now only 370. Out of 22 detoxification facilities, six have been shut down – in spite of the fact that the state has been facing a new heroin epidemic. Five of the residential recovery programs, affecting 267 persons, were removed from service.[10]

Admissions of women to substance abuse treatment services have leveled off since fiscal year 2001. In fiscal year 2001, 31,793 females were admitted to treatment in facilities licensed by the state Bureau of Substance Abuse Services (see Figure 42). By the following year, admissions started to increase slightly: in fiscal year 2002, 31,364 adult women were admitted to substance abuse treatment facilities, and 924 adolescents, for a total of 32,288 female admissions. Only 30,922 adult women and 841 adolescents were admitted in fiscal year 2003. Analysts from the Department of Public Health note that this change has been due to a reduction in capacity for treatment rather than a decrease in need for services.[11] It is important to note that data are not readily available for more recent years – again, because of the Department's diminished capacity to monitor and track public health activities.

Figure 42

Adult (18+) Women Substance Abuse Admissions

FY 2001	*FY 2002*	*FY 2003*
30,795	31,364	30,922

Female Adolescent Substance Abuse Admissions

FY 2001	*FY 2002*	*FY 2003*
998	924	841

With recent reductions in capacity, some programs have had to initiate waiting lists for services which have important clinical implications for treatment. Currently, an individual seeking treatment might have to wait for several weeks before an opening becomes available. In certain parts of the state, such as in the area surrounding Lawrence, there are limited facilities available, and some are a significant distance away. Unfortunately, the window of time in which some people with substance abuse addictions are ready to become sober can be very small, and if a bed is not available at the time the person is ready to make the change, the opportunity for treatment can be lost.

In April 2003, along with the closing of a significant portion of the state's detoxification capacity, health care coverage for some poor women under the MassHealth Basic program was eliminated.[12] Without treatment beds or health care coverage, women seeking help for their addictions were sent for alcohol and substance abuse treatment to the Department of Corrections facility in Framingham for 30 days of substance abuse treatment. In 2002, there were 149 women civilly committed to MCI-Framingham. In just the first half of 2003, there were already 127 women civilly committed. These women tend to place a high demand on the health and supportive systems within the correctional facilities. With diminishing financial support for resources within the community, judges and families have had to look to the correctional system to provide a safety net of public health, mental health and other human services for women.[13] However, there are real risks in taking this approach. According to a Justice within the Quincy District Court, "We cannot simply commit a 17-year –old young man to the Bridgewater Detox with other men who have been alcoholics for 20 to 30 years or a young woman to MCI-Framingham, because there are no other options."[14]

According to a recent study conducted for the Massachusetts Division of Health Care Finance and Policy, each person who remains untreated for drug or alcohol abuse costs society more than $12,000 per year.[15] Even with recent spending increases allocated to substance abuse services for fiscal year 2004, only a portion of this money will be available to rebuild the state's treatment capacity, and the Commonwealth remains a long way from providing adequate treatment, follow-up, and prevention services sufficient to meet the needs of the women and girls in Massachusetts.

Preventing Tobacco Use

The Commonwealth's smoking prevention program presents a dramatic and clear picture of how funding public health programming can have an impact on the Leading Health Indicator of "tobacco use," and on the health of women and girls in the Commonwealth.

Impact on Women and Girls

Smoking has a direct link to the number one and number two killers of women: heart disease and cancer. Lung cancer is the single most deadly form of cancer for women in the U.S. The American Cancer Society estimates that 68,000 women will die of lung cancer in the U.S. in 2004, and approximately 1,600 of these women will be from Massachusetts.[16] Ninety percent of these deaths may be linked to cigarette smoking.[17] Furthermore, the American Cancer Society estimates that there will be more than 4,000 new lung cancer cases diagnosed in Massachusetts in 2004, approximately 1,900 of them women.[18]

"Smoking is the single greatest cause of avoidable morbidity and mortality in the United States," said the U.S. Surgeon General in May 2004 in his report, "The Health Consequences of Smoking." The relationship between smoking and a number of serious health effects has been well documented. Reports have drawn a definite causal link between smoking and cancers of the lungs and larynx, chronic bronchitis, cardiovascular disease, and adverse reproductive outcomes. In March 2004, the U.S. Surgeon General reported that there is a direct causal link between smoking and disease in almost every organ of the body.[19]

The adverse health outcomes due to smoking create enormous economic costs. A study published by the Massachusetts Department of Public Health determined that in 2000, $2.8 billion in personal health care expenditures, and $1.6 billion in lost productivity due to premature death could be attributed to smoking. Moreover, almost $20,000 each day was spent in Massachusetts on neonatal health care costs associated with women who smoked and had given birth the prior year.[20] According to estimates published by the

National Center for Tobacco-Free Kids, $817 million annually is spent by the state for Medicaid coverage of the direct health costs associated with smoking.[21]

Although more men smoke than women, the gender gap has narrowed significantly. According to a study published in April 2004 by the Massachusetts Department of Public Health, in 2002 approximately 20 percent of adult men (age 18 or older) reported that they were smokers, and approximately 18 percent of adult women reported that they were smokers.[22] According to the Surgeon General, national data indicate that poor women and women with lower levels of education are more likely to be smokers, with smoking rates highest among women below the poverty line and with only nine to eleven years of education.[23]

Smoking and Young Women

Close to ninety percent of adults who smoke report that they started smoking before their twenty-first birthday. Half of all adults who smoke report that they were regular smokers by the time they had turned eighteen.[24] In Massachusetts in 1993, 22 percent of high school girls had smoked a whole cigarette for the first time before they were 13 years old. More than 29 percent of high school girls had smoked cigarettes at some point during the previous month.[25] Notably, 64 percent of female high school students had tried to quit, and 63 percent of female high school smokers wanted to quit completely.[26]

There is also significant evidence that quitting smoking is extremely difficult, even for the most motivated to quit. For women and girls in particular, a study conducted in Massachusetts noted that women and girls are resistant to attempting to quit smoking because of concerns about weight gain.[27] Public health departments can play a crucial role both in supporting the efforts of these women and young girls in their attempts to quit, as well as supporting their efforts to withstand inclinations to begin smoking in the first place.

The Massachusetts Tobacco Control Program

Fortunately, there are well-documented strategies that are effective at reducing smoking rates in a population. According to recommendations from the Surgeon General, successful programs should follow a multi-stage approach that involves both the health care system in general and the individual efforts of patients and physicians: "[T]he magnitude and rate of change in smoking behaviors are significantly related to the level and continuity of investments in comprehensive program efforts."[28]

In 1992, the Massachusetts voters passed a referendum to impose a 25¢ per pack tax on cigarettes. This money was made available to fund the Massachusetts Tobacco Control Program (MTCP) within the Department of Public Health, which quickly became one of

the nation's most successful tobacco prevention programs. The MTCP had three main goals:

- Preventing young people from ever starting the use of tobacco products through education and reducing access to those products;
- Encouraging smokers to quit smoking;
- Protecting non-smokers by reducing exposure to environmental tobacco smoke.[29]

By fiscal year 2000, the Massachusetts Legislature voted to supplement the dedicated funding from the cigarette tax with funding from a multi-state master settlement with the tobacco companies. Under the agreement of this settlement, tobacco companies must make annual payments to the settlement states. In Massachusetts, the Legislature determined that these monies would partially be deposited in a permanent trust fund, part of which would be available to fund health-related services.

The first component of the state's comprehensive strategy for preventing smoking was to develop programs that reduce smoking by young people, and prevent them from becoming addicted in the first place.[30] In October 1993, the MTCP developed a media campaign to "Make Smoking History." This broad-based media campaign was designed with the intent of reaching a large audience with information about the negative health effects of smoking. Evaluations of the effectiveness of the ad campaign suggest that it was well-targeted. In particular, young people responded to a series of ads featuring a man whose wife had died of lung cancer at age 46 ("I guess I never thought of 23 as middle-aged!")[31] These ads were aired especially during television shows popular with a young audience, and interestingly, given that people with lower levels of education are more likely to become smokers, people with lower levels of education were more likely to have rated these anti-smoking ads as effective.[32]

The MTCP also worked with the advertising agency developing the ad campaigns to target at-risk and vulnerable populations. There were particular advertising campaigns refined to target non-English speaking smokers, with advertisements translated into Spanish, Portuguese, Chinese, and Vietnamese. The MTCP ran community-based focus groups within these populations in order to develop these specialized media campaigns.[33]

Also starting in late 1993 and early 1994, the MTCP began funding for a wide range of local programs, community-based coalitions, and support for the work of local boards of health and health department programs to combat smoking. The MTCP worked directly with schools and school-based health services and nurses to coordinate and support the anti-smoking messages already delivered to students by the school health services, and also to supplement these efforts with additional resources and materials.[34] The MTCP also developed a system of community-based peer leaders to facilitate efforts to reach young people. The MTCP brought over 1,700 young people into these "youth action alliances" between 1998 and 2000, and close to two-thirds of these youths were girls.

In addition to the media efforts attempted to motivate current smokers to quit, the MTCP developed a variety of educational and treatment efforts to help smokers quit. Local tobacco treatment services, often based within local health care or social service agencies, were a system of evidence-based nicotine addition treatment services provided to smokers.[35]

There were several aspects of the program that were designed specifically to target the particular vulnerabilities of women and girls. Some services provided transportation and child care, in order to make the direct smoking cessation programs accessible to women. In addition, the ability of the tobacco treatment specialists to provide one-on-one community based support allowed the workers to visit women in their homes, thus better meeting the needs of women with young children. MTCP also supported treatment in "safe houses" for women fleeing domestic abuse, mental health day treatment facilities, group homes for pregnant and parenting teens, and retirement communities.[36]

Another one of the major initiatives of the MTCP was the development of a statewide telephone counseling and on-line support service. Designed both for health care provides and individuals, these services provide information, motivation, referral to services and treatment, and counseling. The MTCP online service, www.trytostop.org, provides smoking cessation information and support in thirteen languages.

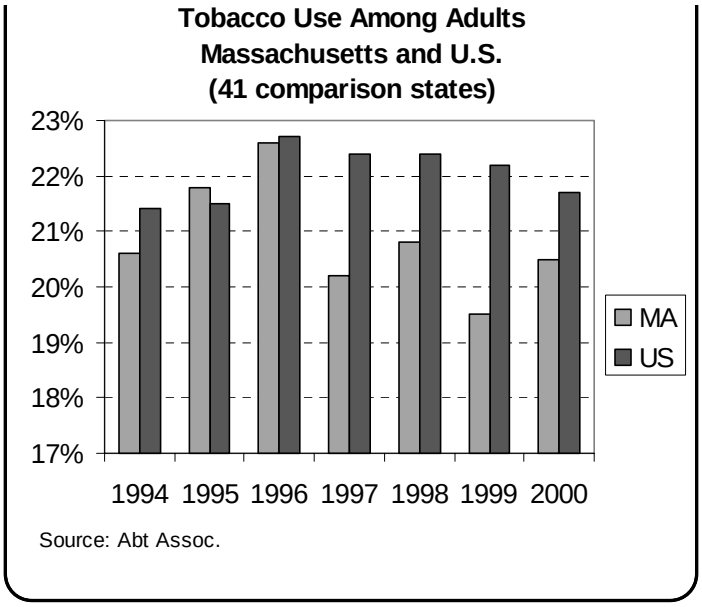
Success of the Massachusetts Program

By fiscal year 2002, the Massachusetts smoking prevention and cessation programs were considered to a model smoking program nation-wide. In fact, according to the Campaign for Tobacco-Free Kids, the fully-funded Massachusetts program was one of only two states (along with California) described as successful due to its being a "long-term and comprehensive public health program."[37]

An analysis of the program determined that the drop in cigarette consumption in Massachusetts between 1990 and 2001 was significantly greater than the drop in consumption nation-wide. In Massachusetts, there were approximately 126 packs of cigarettes sold annually per adult in Massachusetts in 1990, and approximately 72 packs sold annually 2001, a 43 percent drop. Nationally, the rate dropped from 141 packs per capita to 102 packs, a 28 percent decline.[38]

In conjunction with the smoking prevention and cessation efforts, the state implemented an additional increase in the sales tax on cigarettes. At this point, there was strong evidence that the smoking rate in Massachusetts was beginning to drop dramatically. Compared to 41other states nation-wide, the rate of tobacco use among adults dropped from 22.6 percent in 1996 to 20.5 percent in 2000 (see Figure 43). During this same

Figure 43

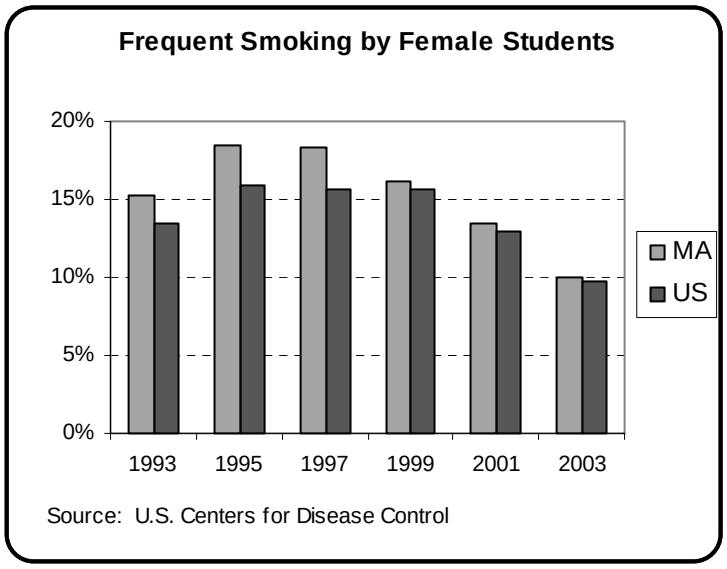


time, the national rate dropped from 22.7 percent to 21.7 percent, a reduction of only four percent.[39]

Significantly, smoking among young people also declined in Massachusetts. Among high school students in Massachusetts, smoking declined by 27 percent between 1992 and 2001, from 35.7 percent to 26 percent.[40]

The MTCP had an influence on smoking among adolescent females as well. Although the rate of frequent smoking among these teenagers was higher than the national average by several percentage points at the inception of the MTCP, as the program progressed, the percentage of female adolescents who were frequent smokers (defined as smoking twenty or more cigarettes during the past month) dropped more rapidly in Massachusetts than in the nation as a whole. According to the national Youth Risk Behavior Survey, frequent smoking by adolescent girls (as measured by having smoked cigarettes on twenty or more of the past thirty days) in Massachusetts dropped by 46 percent between 1995 and 2003, from 18.5 percent of students to 10 percent. During that same time, the national reduction in frequent smoking among adolescent females was only 39 percent (see Figure 44).

Figure 44

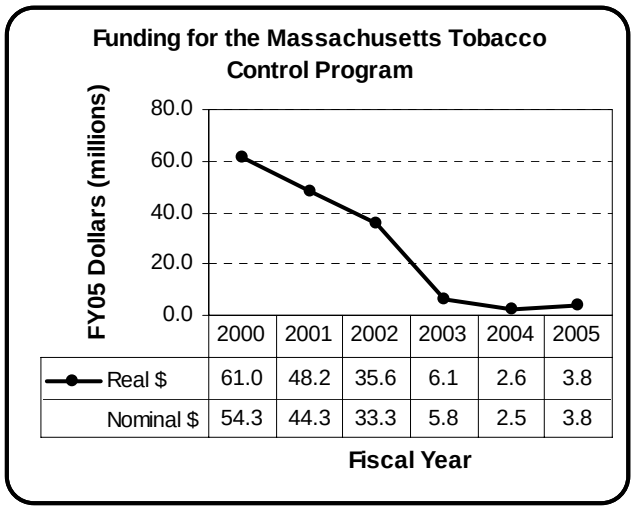


Even more dramatically, smoking during pregnancy in the Commonwealth declined during the years of the MTCP. Between 1993 and 2000, smoking among pregnant women fell from 17 percent in 1993 to 10 percent in 2000, a 39 percent decline. This drop is much steeper than the national rate during that same period which was 24 percent.[41]

Funding

Since the state fiscal crisis began in fiscal year 2002, the successful Massachusetts Tobacco Control Program has been decimated (see Figure 45). From its peak in 2000, when the MTCP was funded at $54.2 million, or $61.0 million in inflation-adjusted dollars, continual cuts have almost entirely eliminated all phases of the program.

Figure 45



	2000	2001	2002	2003	2004	2005
Real $	61.0	48.2	35.6	6.1	2.6	3.8
Nominal $	54.3	44.3	33.3	5.8	2.5	3.8

Although there was a real reduction of $12.6 million between fiscal year 2001 and 2002 – a reduction of more than 26 percent of the MTCP budget – the steepest decline in funding was between fiscal year 2002 and 2003. During that period, the program sustained a real reduction of $29.5 million, reducing its budget another 83 percent. Continued reductions through fiscal year 2004 brought the program's funding level down to $2.6 million when adjusted for inflation. Even with the $1.2 million increase in the fiscal year 2005 budget, between fiscal year 2000 and fiscal year 2005, funding for the Massachusetts Tobacco Control Program had been reduced by close to 94 percent in real terms.

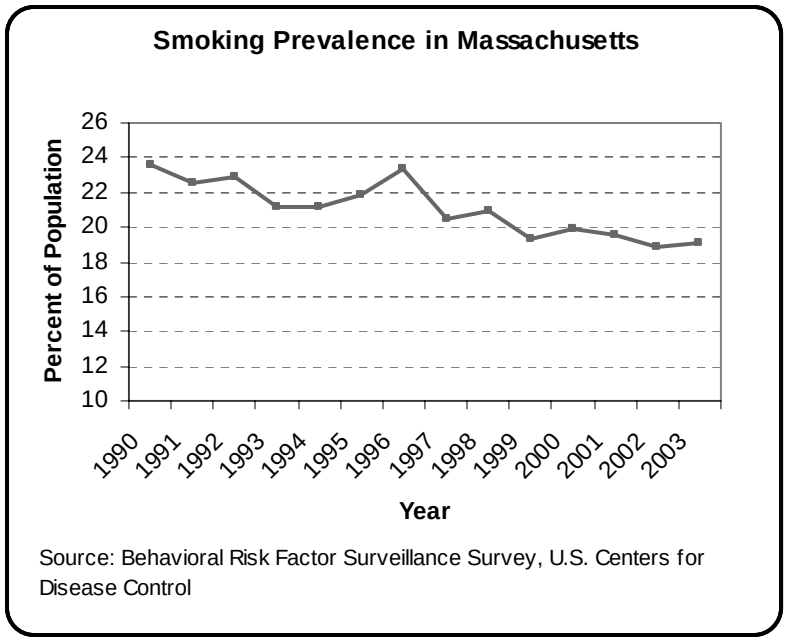
Impact of Funding Cuts

The reductions in funding for the Massachusetts Tobacco Control Program eliminated most of the innovative prevention programs run by the Department of Public Health. By 2003, the media campaign and the community-based programs suffered the most substantial cuts. In real terms, funding for the media campaign dropped from about $22.5 million in 2000 to zero by 2004.

It was not just the media campaign that sustained deep cuts during this time, however. Local program funding dropped from $27.5 million (in 2005 dollars) to approximately $1.5 million, with small amounts of money only available to support local boards of health and community coalitions.[42] In addition, innovative marketing grants that had included local advertising and pre-movie advertising − a special initiative directly targeted at preventing young people from starting smoking − were also eliminated by fiscal year 2003,[43] as was funding for smoking cessation and treatment services.

By fiscal year 2003, many of the specialized outreach programs that had especially met the needs of women smokers were eliminated, such as home-based services for women with young children who would be unlikely to go to a health center-based tobacco treatment program.

Figure 46



Source: Behavioral Risk Factor Surveillance Survey, U.S. Centers for Disease Control

One of the hallmarks of the Massachusetts Tobacco Control Program when it was fully funded was an evaluation component that allowed the Department of Public Health to continually refine its program operations based upon what was successful. Whereas $4.6 million (in real dollars) had been allocated for research and evaluation in fiscal year 2000, only $20,000 was left for research and evaluation in fiscal year 2004. Accordingly, the Department no longer has the capacity to track effectively the services provided by the program and to evaluate the impact of the reduction in those services.

Nevertheless, the evidence that does exist seems to suggest that after deep cuts in the Massachusetts Tobacco Control Program, smoking rates stopped declining (see Figure 46). Recent data from the Behavioral Risk Factor Surveillance System of the federal Centers for Disease Control suggest that the decline in the prevalence of smoking in Massachusetts has leveled off. Whereas the rate of smoking in 2003 as measured by the Centers for Disease Control was 18.9 percent of the population, in 2004 it was 19.1. Additional research is needed however because the sample sizes in this survey are not sufficient to demonstrate that this difference is statistically significant.[44]

The reduction in funding for the services provided by the Massachusetts Tobacco Control Program may also be allowing an increase in the illegal acquisition of cigarettes by minors. Although data are not yet available on statewide or national youth smoking rates for 2004, a recent study conducted by Tobacco Free Mass indicated that communities that experienced dramatic reductions in tobacco control funding have experienced a corresponding increase in illegal sales of cigarettes to minors.

Retail compliance is measured by sending a minor, under adult supervision, into a retail establishment to purchase cigarettes illegally. Between 2002 and 2003, retail non-

compliance jumped from eight percent of attempted undercover purchases to almost 14 percent in communities with reduced tobacco control programs. In those communities where tobacco control funding was completely eliminated, the average rate of illegal sales to minors almost doubled – from 7.7 to 15.4 percent.[45]

In response to the release of these data, Massachusetts Attorney General Thomas Reilly stated, "This survey shows what can happen when funding is cut – more kids get access to tobacco."[46] Just as the Massachusetts Tobacco Control Program was an example of demonstrable success in protecting the health of women and girls in Massachusetts, the state's fiscal crisis and the budgetary decisions that resulted threatened the ability of the Commonwealth to protect the health of women and girls and prevent or treat smoking.

Providing Access to Reproductive Health Care

Another of the Leading Health Indicators is "responsible sexual behavior." The Department of Public Health provides services to influence women's reproductive health in the family health programs, the communicable disease prevention programs, and the HIV/AIDS Bureau. Assisting women in achieving healthy pregnancies and outcomes has a significant impact on the health of the entire community.

According to results from a survey conducted by the Massachusetts Department of Public Health in 2002, among sexually-active women of reproductive age (18-44) who were currently pregnant or had been pregnant within the past five years, 25 percent reported that they had had an unplanned pregnancy. Among these women, the rate of unplanned pregnancy was five times higher for women aged 18-24 than for women aged 35-44. Of even more concern is that unplanned pregnancies tend to be associated with women who are younger, who have lower levels of education, and who live in lower income households.[47]

Family planning services are essential for helping women prevent unintended pregnancies, especially since women with unintended pregnancies and their babies tend to have poorer health outcomes.[48] According to a recently-published report by the Institute of Medicine, children born from unintended pregnancies are at greater risk of being born at a low birth-weight, being victims of abuse, or being born into circumstances where there are insufficient resources for healthy development.[49]

There are many direct benefits to reducing teen pregnancy rates in particular. Fewer than one-third of teenagers who begin their families before the age of 18 ever earn a high school degree, and only 1.5 percent earn a college degree by the age of 30. Teen mothers are more likely to have low weight gain during pregnancy, complications of pregnancy, and certain health problems later in life. Children born to teen mothers are more likely to be born with low birth weight and other health problems. Children born to teen mothers

are also at higher risk for receiving inadequate parenting, or being abused or neglected.[50] Furthermore, the state Department of Transitional Assistance has reported that more than 70 percent of teen mothers at some point require public assistance.[51]

Once a woman is pregnant, strong reproductive health programs can ensure access to appropriate prenatal care, can reduce complications during childbirth, and can provide treatment of complications if, and when, they occur.[52] These efforts require a "public health strategy that is culturally and linguistically appropriate and ensures that women receive high-quality health services, including family planning counseling, prenatal and pregnancy care, and care after childbirth for both physical and mental health needs."[53] The reproductive health services of the Massachusetts Department of Public Health have been designed to fit into this public health strategy. As stated by the Department of Public Health in its own description of the Family Planning Program:

> [F]amily planning services aid individuals and families in making choices regarding the spacing and number of their children. Family planning is an integral component of the Department of Public Health's efforts to prevent unintended pregnancies and STDs including HIV/AIDS, reduce infant mortality and morbidity, and improve the health of women and men of all ages.[54]

Publicly-supported family planning services are provided throughout the Commonwealth, in more than 80 sites sponsored by more than a dozen different agencies. These clinic-based programs provide gynecological exams, breast exams, screening for cervical cancer, diagnosis and treatment of sexually transmitted diseases, birth control counseling and access to birth control devices, pregnancy testing, follow-up and referral for identified medical problems, preconception care for women planning a pregnancy, and counseling and testing for HIV/AIDS. These clinics also provide education and outreach to promote healthy and responsible decision-making about sexuality and reproduction.[55]

Services at these publicly-supported clinics are provided to women and adolescents at or below 200 percent of the federal poverty level; half of the people served live below 100 percent of the poverty level.

Impact on Women and Girls

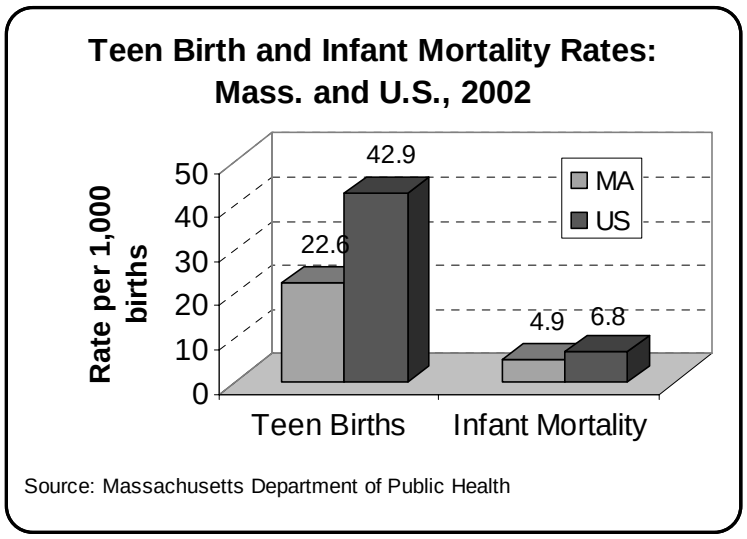
The intent of the state's support for reproductive health initiatives is to improve pregnancy and birth outcomes for women of all ages and to reduce the rate of sexually-transmitted disease. There is substantial evidence that the Commonwealth's public health efforts in the area of reproductive health have done exactly that.

For many low-income women and children, the network of state-funded family planning and reproductive health centers provide their only access to reproductive counseling, gynecological care and prevention services. This health network has been particularly

crucial to the state's strategy for reducing the number of unintended pregnancies in the Commonwealth, particularly among teenagers.

One of the targeted state efforts to prevent teen pregnancy has been the Teen Challenge Fund Program. Started in the late 1980s, the intent of this effort was to develop locally-based initiatives to increase community awareness of the risks and problems associated with teen pregnancy. The goals of this program were to increase abstinence, and to delay the onset of sexual activity among pre-adolescent and adolescent males and females, and to reduce the rate at which young people engage in risky behaviors, including risky sexual behavior. Ultimately, the goal of the program was to decrease the incidence of teen pregnancy and births, and the rate of sexually-transmitted diseases and HIV infection.[56] The Challenge Fund supported seventeen coalitions in communities with socio-economic characteristics that put them at high risk for a higher rate of teenage pregnancy.

Figure 47



In addition, starting in 1998 Massachusetts implemented a federally-funded state-wide media initiative promoting abstinence. This program has targeted its efforts in the Hispanic and African-American communities that have had disproportionate numbers of births to teenagers.

Improvements in several public health measures give encouraging support to arguments for adequate funding of public health services. According to a study released by the Department of Public Health in February 2004, the teen birth rate in Massachusetts is at its lowest rate ever, and is 47 percent below the national average (see Figure 47). For young women ages 15-19 in Massachusetts, the birth rate was 35.4 births per 1,000 women in 1990, and just 22.6 in 2002. The national rate in 2002 was 42.9 births per 1,000 women.[57]

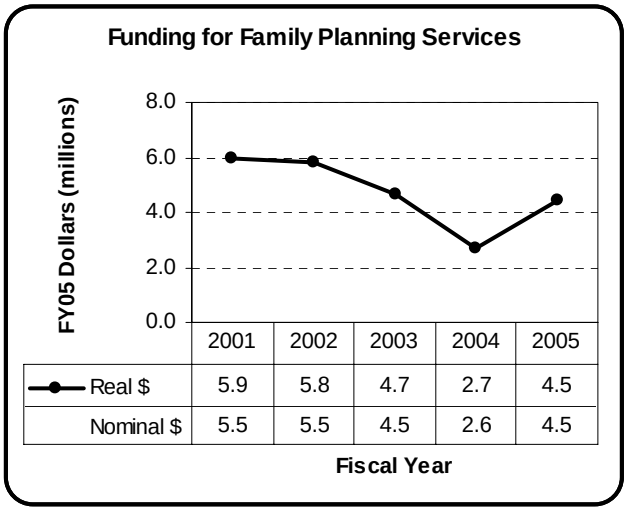
Equally important, as the figure indicates, the infant mortality rate in Massachusetts has also continued to decline. In 2002, there was the second lowest number of infant deaths in Massachusetts history. Upon the release of this information, Commissioner of Public Health Christy Ferguson stated: "We need to remain diligent to continue making progress in the reduction of teen pregnancies and in the infant mortality rate and to address

disparities. Overall, this report indicates that Massachusetts has a lot to be proud of concerning the health of its mothers and their babies."[58]

According to national data, by the period from 1999 to 2001, the Commonwealth ranked fifth best among all states in the percentage of women who received early and adequate prenatal care, a rate of 83 percent. From the period of 2000 to 2002, Massachusetts ranked eleventh best in the percentage of women receiving Pap smears.[59]

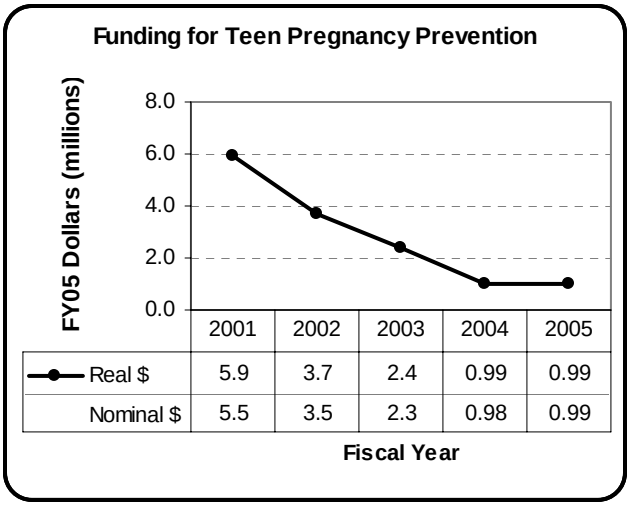
Funding

Figure 48



Since fiscal year 2001, funding for women's reproductive health services has been significantly reduced (see Figure 48). Funding for family planning programs remained essentially level during fiscal years 2001 and 2002, but the cut in fiscal year 2003 represented a decrease of 20 percent, or $1.2 million in real dollars. There was an additional 42 percent real cut in fiscal year 2004. Restoration of funding in fiscal year 2005 returned the level of support for family planning to just under the amount funded fiscal year 2003 in real dollars, but even at this level there has been a 25 percent reduction in funding when adjusted for inflation since fiscal year 2001.

Figure 49



The teen pregnancy prevention programs were cut even more dramatically than the family planning programs (see Figure 49). In real terms, funding for the teen pregnancy prevention programs was $6.0 million dollars in 2001. A one-year cut between fiscal year 2001 and 2002 reduced support by 38 percent in real terms; and then funding was cut the subsequent year by another 35 percent.

Between fiscal year 2001 and 2005, in real terms funding was cut by more than $5.0 million. For a program that only started with $6.0 million, this represented a reduction of more than 83 percent.

Impact of Funding Cuts

Among the dollars cut from family planning services was a $1 million reduction in funding for outreach services. Because the earliest weeks of fetal development are crucial to the ultimate health of an infant, eliminating the supports that get high-risk women into prenatal care at the earliest part of their pregnancies has the potential to have a significant impact on birth outcomes. Poor early prenatal care can have an impact on infant birthweight and whether the mother will carry the infant to full term. There are estimates that over 16,000 women and adolescent girls will lose access to screening for sexually-transmitted disease, screening for breast or cervical cancer, or other family planning services with these funding reductions.[60]

Starting in fiscal year 2002, deep cuts to services were also felt in teen pregnancy prevention programs. According to the Massachusetts Alliance on Teen Pregnancy, in 2003 there were seventeen Teen Challenge Fund Program coalitions. These coalitions provided services to adolescent girls from within 97 community agencies. Close to 24,400 youth, parents and community members had been reached by these public health programs.[61] By fiscal year 2004, fifteen of these coalitions had been eliminated, leaving only two. Funding cuts have dramatically limited the scope of these programs, particularly outreach and prevention.

Although there is a slight funding increase in the teen pregnancy program for fiscal year 2005, the budget earmarks $500,000 of the funding for specific communities in western Massachusetts. The remaining $490,000 is available to serve the rest of the state. The Department of Public Health intends to use these dollars for direct services, and only in seven communities. This will leave many communities of the Commonwealth with no resources with which to address teen pregnancy prevention, whether through outreach, education or direct services.[62]

Tracking the impact of funding reductions in reproductive health supports always involves a time lag. However, over the next few years it will be important to monitor any changes in the rates of teen pregnancy, low birthweight infants, and incidents of sexually-transmitted diseases or cervical or breast cancers in low-income women and girls.

Services for Teen Parents and their Families

In addition to coordinating with the Department of Public Health on early intervention strategies, the Office of Child Care Services administers its own program for at-risk newborns. The Healthy Families/Newborn Visiting Program provides services to first time parents under the age of 21 and their families. Comprehensive, prevention-oriented services are delivered by trained home visitors at or before the child's birth, and until the child is three years of age. Families receive information on childbirth and infant care,

and also training on basic life skills like developing a family budget or mapping educational goals.

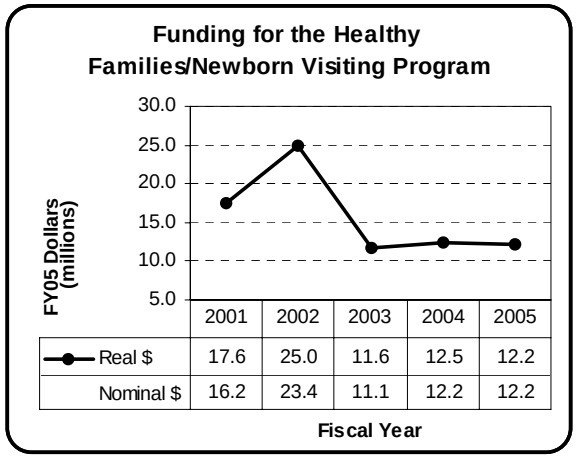
Impact on Women and Girls

More than 13,000 families have benefited from the Healthy Families/Newborn Visiting Program since its start in 1997.[63] According to data from fiscal year 2003, of those participating in the program, nearly 60 percent enrolled during their pregnancy, a fundamental precursor to positive birth outcomes.[64] The program also provided services to very young mothers; approximately 20 percent of participants were 16 years and younger.[65] Despite the overwhelming odds teen parents face, the program appears to be achieving desired results: 84 percent of mothers enrolled in the program have graduated from high school or are continuing their education; 87 percent of participating families have not had a substantiated case of child abuse or neglect; only 6 percent of these teen mothers have experienced a repeat birth while enrolled in the program over a three year period.[66] The home visiting program helps teen mothers and their children to escape negative consequences often associated with teen parenting.

Funding

Between fiscal years 2002 and 2004, funding for home visits for at-risk newborns fell substantially. Between fiscal years 2002 and 2003, funding fell from $23.4 million to $17.1 million, a 28 percent reduction in real terms (see Figure 50). In fiscal year 2003, mid-year budget cuts further reduced funding for this program by $6.0 million. Although the fiscal year 2005 budget level-funds home visits at $12.2 million, the amount appropriated is $12.7 million or 51 percent below the fiscal year 2002 level after adjusting for inflation.

Figure 50



	2001	2002	2003	2004	2005
Real $	17.6	25.0	11.6	12.5	12.2
Nominal $	16.2	23.4	11.1	12.2	12.2

Impact of Funding Cuts

Budget cuts have limited this program's ability to provide effective, preventive services to teen mothers and their families. Annually, more than 6,200 teenagers give birth for the first time in Massachusetts, but the program has never been funded to serve all first-time parents for a full three years.[67] In fiscal year 2003, mid-year cuts led to the elimination of 150 staff positions, and approximately 1,000 families were prematurely discharged from the program. In fiscal year 2004, when the budget was cut by nearly $5.0 million from

the initial fiscal year 2003 appropriation, the number of families receiving services fell from 5,402 to 4,442.[68] The fiscal year 2005 budget essentially level-funds this program at $12.2 million, which is enough to provide services to 4,346 individuals.[69] Budget cuts to this program jeopardize a program with a proven track record.

By limiting the availability of services, Massachusetts runs the risk of reversing the above mentioned accomplishments. The program's positive effect on low occurrence of child abuse is substantial since one-third of the participants are victims of abuse themselves and are at greater risk for perpetuating abuse or neglect.[70] The low occurrence of repeated birth among participants is also significant. Compared to teen mothers with only one child, teen mothers who have two or more children exhibit lower educational attainment, face a greater likelihood of poverty, and run a greater risk of impairing their children's health.[71]

Protecting Women and Girls from Infectious Disease

There is a close relationship among the services provided to improve the reproductive health of women and girls and the services specifically targeted to controlling the spread of infectious disease, particularly the diseases spread most commonly through substance abuse or those that are sexually-transmitted. A recent study published by the National Center on Addiction and Substance Abuse at Columbia University found that there is "a tight connection between teen sexual behavior and dating and teen risk of smoking, drinking and using illegal drugs."[72]

Although Massachusetts often ranks well compared to other states in a number of public health measures, in one compilation of a wide variety of public health measures affecting women, 38 states had lower AIDS rates among women than Massachusetts, and 24 states had lower rates of Chlamydia.[73] Compared to other states, Massachusetts has a higher rate of many sexually transmitted diseases, especially among adolescents. This is particularly problematic for young women, as the presence of other sexually transmitted diseases makes them more vulnerable to infection with HIV/AIDS.[74]

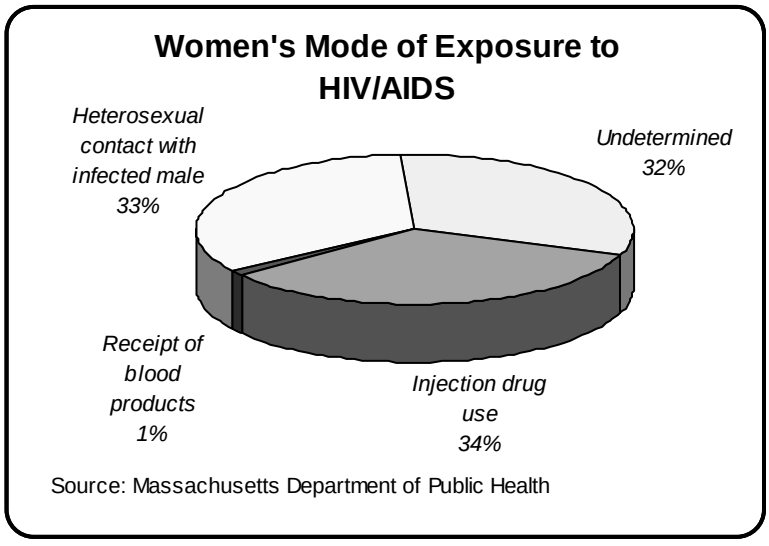
Hepatitis C, which may be transmitted through sexual activity, is more frequently associated with direct blood to blood transmission. This can happen through intravenous drug use, unsanitary tattoos or piercing equipment, or any other way that someone might come in contact with tainted blood. Hepatitis C is the most common blood-borne virus in the nation, and there is no vaccine to prevent it. Hepatitis C can lead to cirrhosis of the liver, liver cancer, liver failure or death, and is the leading indication for liver transplants. However, some people with Hepatitis C may be relatively symptom-free for years, and might be at risk of transmitting the disease to others while infected.

Since the presence of Hepatitis C is the leading indicator for liver transplants, preventing, detecting and slowing the progress of Hepatitis C can have significant impacts on costs to the health care system. Primarily because of the connection to substance abuse, Hepatitis C is often closely related to HIV. There are estimates that 60-80 percent of HIV-infected intravenous drug users are also infected with Hepatitis C. Similarly, there are estimates that 10-20 percent of Hepatitis C-infected drug users are co-infected with HIV.[75] Within the correctional system, 44 percent of the female inmates in Massachusetts are infected with Hepatitis C.[76]

Impact on Women and Girls

AIDS is increasingly becoming a women's health issue. In 2001 women represented 30 percent of all new AIDS cases nation-wide. Furthermore, AIDS is taking a particular toll on women of color, especially African-American women. Even though African-American women are only 12 percent of the nation's population, 64 percent of new HIV infections in women occurred in African-American women. Hispanic women are also over-represented among those with new HIV infections: in 2001 they were 13 percent of the population, but 18 percent of all new HIV infections.[77]

Figure 51



These percentages are consistent with trends in Massachusetts. According to the Massachusetts AIDS Surveillance Report, 29 percent of Massachusetts residents with AIDS in 2003 were women. Also similar to the national statistics are racial/ethnic disparities in the incidence of AIDS among women: the prevalence of AIDS among African-American women in Massachusetts is 19 times greater than for white women; and the prevalence for Hispanic women is 13 times greater than for white women. In addition to representing an increasing proportion of the HIV/AIDS diagnoses, women represent an increasing proportion of the HIV/AIDS-related deaths. In 1990, 12 percent of deaths among persons reported with AIDS were women. By 2002, 27 percent were women.[78]

Women have a pattern of exposure to HIV/AIDS that differs from the ways that men are exposed. Whereas the most frequent form of exposure for men (currently alive with HIV

or AIDS in Massachusetts) to the virus was through homosexual contact with an infected male (41 percent), 28 percent of men were exposed through injection drug use.[79] For women, the most frequent form of exposure to the virus was through injection drug use (34 percent – see Figure 51).

The other significant source of exposure for women is through heterosexual contact with an infected male partner (33 percent). Given these statistics, there is a public health imperative to help women learn how to protect themselves from being infected and then exposing others.

The state provides services to women with HIV/AIDS through program called AIDS Care and Treatment Now (ACT – Now) at a network of clinical sites funded by the Department of Public Health. These clinics provide prevention education and counseling, screening, and primary and preventive medical care to low-income and uninsured or underinsured people with HIV/AIDS. In the spring of 2004, the state listed fifteen ACT – Now sites across the state.

Just as the family planning programs funded by the Department of Public Health provide direct reproductive and prenatal care to women, they have also been instrumental in screening women and treating them for Hepatitis C, HIV/AIDS and other sexually-transmitted diseases (STDs). In addition to the sites providing primary care, the Department of Public Health also provides funding to a larger network of sites across the state that provide HIV counseling, testing, and screening for at-risk individuals, as well as vaccination for viral Hepatitis and screening or referral for other sexually-transmitted diseases.

The dramatic reductions in the number of infants born infected with HIV provide evidence for the benefits of the state's public health efforts. An evaluation of the Massachusetts HIV/AIDS services suggests that the state's screening program may have had a significant impact on the number of infants born infected with HIV. This evaluation makes the connection between perinatal transmission of HIV infection and the availability of screening programs. It states:

> The percentage of known HIV infection transmitted perinatally among mothers known to be HIV positive who gave birth in Massachusetts has decreased markedly in the past ten years, from 26% . . . in 1992 to 0% in 2001. The decrease in transmission rate has been attributed to screening programs for pregnant women and increased use of antiretroviral therapy in pregnant women and their infants. In 2001, 100% of HIV-positive women who know their status before giving birth received antiretroviral therapy during pregnancy and/or during labor and delivery. This marks an increase from 89% in 1996.[81]

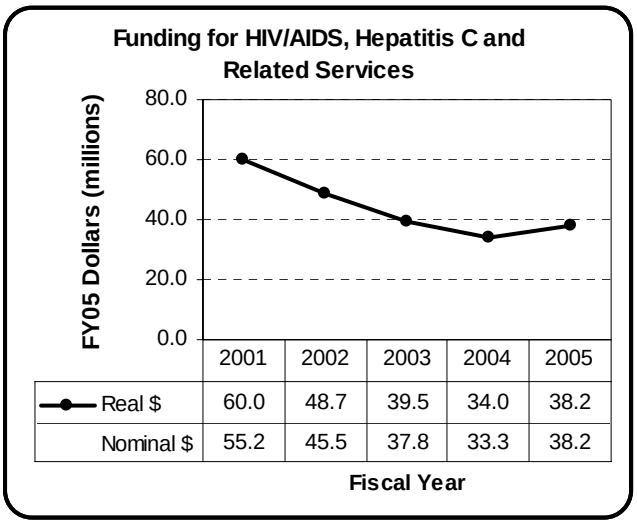
State programs have been effective at slowing the spread of HIV/AIDS, and also at improving the health of women living with HIV/AIDS. There is evidence that declining

rates of AIDS diagnosis may suggest the delaying of severe disease.[82] According to the Department of Public Health, the state's aggressive approach which combined outreach, prevention education, counseling, testing, and clinical care services made Massachusetts a national leader in reducing deaths from AIDS, limiting and identifying new HIV infections, and encouraging responsible and protective behaviors among persons at risk for infection or transmission.[83]

Funding

Funding for the infectious disease programs, including funding for the Hepatitis C program, the AIDS Bureau within the Department of Public Health, and special funding for housing programs for people living with HIV/AIDS, has dropped dramatically since the beginning of the state's fiscal crisis (see Figure 52).

Figure 52



Between fiscal year 2001 and 2005, funding dropped from $60.0 million to $38.2 million, a reduction of close to $22 million in real terms. Between fiscal years 2001 and 2002 and between fiscal years 2002 and 2003, there were cuts of 19 percent. Although the reductions were less severe in following years, the total reductions have been significant – a reduction of more than 36 percent between fiscal year 2001 and fiscal year 2005. The recent addition of funding in a supplemental budget allocated to fiscal year 2005 still does not bring funding for these services back to the level they were before the fiscal crisis. Funding is still at only two-thirds the level it had been previously.

Impact of Funding Cuts

The Commonwealth has made dramatic reductions to HIV/AIDS prevention and treatment services. Thousands of people lost the case management and transportation services which helped them maintain complicated medical regimens.[84] Without these essential supports, women infected with HIV/AIDS are less likely to take appropriate care of themselves, and are more likely to spread the infection.

Cuts in fiscal year 2003 reduced funding available for HIV screening programs, thereby eliminating funding for 10,000 HIV tests. Funding reductions also eliminated screenings

and access to prevention services for HIV, Hepatitis C and other sexually transmitted diseases in the houses of correction.[85] Cuts in fiscal year 2003 also eliminated special funding for model housing programs for persons with AIDS.

In fiscal year 2004, there were further reductions in services. The number of HIV tests conducted by clinics was reduced by close to 6,000. Furthermore, the AIDS Bureau eliminated a program serving women in recovery from addiction and a program for other high-risk women with substance abuse problems.

In fiscal year 2004, the Commonwealth eliminated a special budgetary allocation targeted to prevention and screening for Hepatitis C (often affecting women in prison and women who are intravenous drug users.) With the elimination of this dedicated funding stream, it became necessary to reallocate other money to meet the specific needs of this population. Even though Hepatitis C and HIV/AIDS are often co-morbid infections, they require very different treatments and approaches.

It is also important to keep in mind that changes in the MassHealth program during the fiscal crisis also significantly affected persons with HIV/AIDS. Because many people who become sick with AIDS are increasingly unable to work as the disease progresses, they are more likely to have an income level low enough to qualify for MassHealth. The changing eligibility thresholds, the increased premiums for services, as well elimination of certain benefits such as dental services also significantly affected this population at the same time they were losing direct services through the Department of Public Health.

Treating and Preventing Domestic Violence

Funding for domestic violence services increased substantially in the mid to late 1990s. In 1992, after a sharp increase in domestic violence-related homicides, Massachusetts declared this issue to be a public health crisis. Currently, the Massachusetts Department of Social Services (DSS) is the main agency charged with overseeing services for survivors of domestic abuse. Working with other agencies, including the Department of Transitional Assistance, DSS provides resources to both treat and prevent domestic violence. Services include batterer intervention programs, shelters and safe houses, and community-based programs for survivors of domestic abuse.

There are many other state-funded programs that are not primarily focused on preventing domestic violence, but are likely to work toward this end. For example, the Department of Transitional Assistance's Teen Living Program provides shelter and other services to teen mothers receiving TAFDC. While the primary focus of the Teen Living Program is not to prevent or end abuse, providing shelter for teen mothers and their children may assist with this goal, as many of the mothers were or are victims of domestic violence.

This section will highlight only the services that are principally designed to treat or to prevent domestic violence.

Impact on Women and Girls

Domestic violence affects women far more often than men. According to data from the Department of Justice, 85 percent of victims of domestic violence are women.[86] Abuse – whether it is physical or emotional – negatively affects the physical, mental, and economic well being of women and their children.

- In addition to harming women's physical health, domestic violence often leads to mental health issues like depression and anxiety. A survey on women's health by the Commonwealth Fund reported that women who had been abused were nearly twice as likely to have depressive symptoms or to have been diagnosed with depression or anxiety.[87] The study also found that abused women were twice as likely as other women to have problems with accessing health care.[88] Other findings suggest that women with a history of violence or abuse were more likely to have a disability or illness that limits their work or daily activities.[89]

- Very often children of abused mothers are abused themselves or suffer from witnessing violence in their homes. These children are at risk for or may exhibit developmental delays, irreversible psychological damage, or replication of violent behavior.[90]

- Domestic violence poses a serious barrier to women securing and maintaining employment. A review of research by the General Accounting Office indicates the effects of domestic violence can impact women's professional performance and hinder their ability to maintain or advance in their job.[91] Abusive partners may also undermine women's efforts to become financially independent.[92]

- Although domestic violence affects women of all socioeconomic backgrounds, the incidence of abuse among TAFDC recipients is high. A 1997 report on the prevalence of domestic violence within the TAFDC caseload indicates that 20 percent of recipients had been abused by a current or former boyfriend or husband within 12 months of the study.[93] Nearly two-thirds (65 percent) had been abused by a current or former boyfriend or husband at some point in their lives.[94]

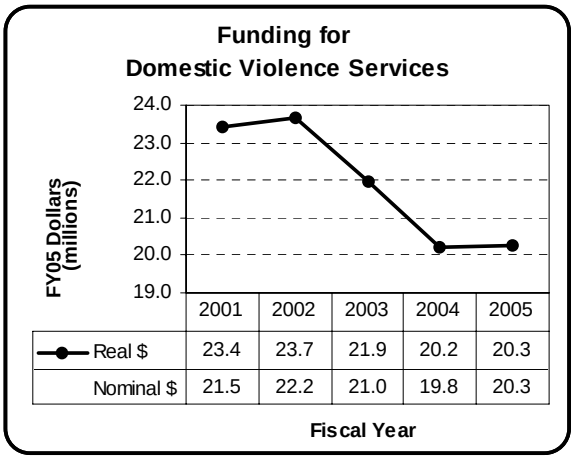
In 1987, the Department of Social Services began to provide targeted services to battered women and their children, as children are often abused in these families. One specific strategy was the establishment of a Domestic Violence Unit, in which specialists directly advocate on behalf of abused women and their children.[95] Domestic Violence Specialists also train DSS case managers and social workers to identify victims of domestic violence

and to develop strategies to serve affected families; they also collaborate with other agencies and organizations to educate the community about the relationship between domestic violence and child welfare.[96] Currently there are Domestic Violence Specialists in area offices for both the Department of Transitional Assistance and the Department of Social Services.

Between fiscal years 1992 and 2002, resources were devoted to assisting survivors of domestic abuse and treating their batterers and overall funding for domestic violence services grew from $7.5 million to $21.6 million (or $23.1 million in 2005 dollars). Collaborations among the Departments of Public Health, Transitional Assistance, Social Services, and Housing and Community Development led to increased access to services including: batterer's intervention, community-based intervention and treatment programs, and shelters and transitional housing. Massachusetts also provides waivers for abused TAFDC recipients, which allow exemptions or extensions from the two-year time limit on benefits and work requirements, though only a small proportion of the entire caseload actually receives them.[97]

Funding

Figure 53



Between fiscal years 2002 and 2004, overall funding for domestic violence services fell by $3.4 million or 16 percent in real terms (see Figure 53). Prior to fiscal year 2004, funding for domestic violence services was distributed among four different agencies. The fiscal year 2004 budget consolidated funding sources such that programs previously funded through the Department of Public Health and Department of Housing and Community Development now fall under the purview of the Department of Social Services. Although there likely were administrative savings from consolidating resources, savings were also achieved by eliminating actual services. For example, the Refugees and Immigrants Safety Enrichment (RISE) program was completely eliminated.

Impact of Funding Cuts

RISE operated fifteen programs across the Commonwealth, offering outreach, crisis intervention, and advocacy services to immigrant and refugee communities.[98] This program, which in fiscal year 2002 served roughly 1,000 women and nearly 2,000 children, provided culturally and linguistically appropriate strategies to prevent domestic violence.[99] The RISE program was a valuable resource, as it offered services in 18

different languages and to women from 25 different ethnic backgrounds.[100] In addition to counseling and intervention services, the RISE program referred women to housing, employment, legal, and educational services.[101]

Other budget cuts are likely to compromise both the availability and quality of domestic violence services. These reductions come at a time when demand for such services is high. Between fiscal years 2001 and 2003, the number of intakes for domestic violence shelters and safe homes grew from 2,754 to 3,752.[102] In fiscal year 2003, shelters and safe homes reported roughly 6,000 incidents when individuals were turned away from such services.[103] These resource shortages occur in conjunction with cuts in other areas that provide supports to survivors of domestic violence, particularly housing and employment supports, which are reviewed in Section II: Providing Economic Security to Women and Families. Securing a safe place to live and a sufficient income is essential for women who wish to escape violent circumstances.[104] Despite the threat domestic violence poses to women and their families, the Commonwealth has reduced its support for treatment and intervention.

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[26] "Trends in Tobacco Use," American Lung Association, June 2003, Table 19.
[27] Beiner, L., "Tracking Change in Response to the Massachusetts Tobacco Control Program," Summary Findings, available at www.phs.bgsm.edu/sshp/rwj/FundedGrants/FindingsSummaries/Beiner.html.
[28] U.S. Surgeon General, "The Health Consequences of Smoking: A Report of the Surgeon General," May 27, 2004, Executive Summary, p.15, available at www.cdc.gov/tobacco/sgr/sgr_2004/pdf/executivesummary.pdf.
[29] The MTCP has now also developed a fourth goal: Identifying and eliminating tobacco-related disparities among specific population groups.
[30] The following description of the development of the Massachusetts Tobacco Control Program is adapted from overviews of the program in Connolly, G., Robbins, H., "Designing an Effective Tobacco Control Program – Massachusetts," and Hamilton, W., diStefano Norton, G., and Weintraub, J., at Abt Associates, Inc., "Independent Evaluation of the Massachusetts Tobacco Control Program, 7th Annual Report - January 1994 to June 2000." These reports are available at www.mass.gov/dph/mtcp/reports/reports.htm.
[31] This ad is described in full in as a Causemarket.com "pick of the month" available at www.causemarketer.com/picks.html.
[32] Beiner, L., "Tracking Change in Response to the Massachusetts Tobacco Control Program," Summary Findings, available at www.phs.bgsm.edu/sshp/rwj/FundedGrants/FindingsSummaries/Beiner.html.
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[37] "Program and Funding Guidelines for Comprehensive Tobacco Control Programs," Campaign for Tobacco-Free Kids, at www.tobaccofreekids.org/reports/settlements/cdc-report.shtml.
[38] Although some of the reduction in cigarette purchasing in Massachusetts could be a result of cross-border cigarette purchases in New Hampshire, an analysis of purchasing trends in Massachusetts and New Hampshire between 1992 and 1998 determined that even if the entire increase in cigarette sales in New Hampshire during this period were attributed to Massachusetts smokers crossing the border to purchase cigarettes, there was still a 24 percent reduction in per capita cigarette consumption in Massachusetts. It is therefore reasonable to assume that a significant portion of the decline in Massachusetts is a result of an actual decline in smoking prevalence. See also Hamilton, W., Rodger, C., Chen, X., Njobe, T., Kling, R., Norton, G., "Independent Evaluation of the Massachusetts

Tobacco Control Program, Eighth Annual Report: January 1994-June 2001," Abt Associates Inc., chapter 1, p. 12-13, available at www.mass.gov/dph/mtcp/reports/reports.htm.

[39] The national comparison excludes California, which also had a comprehensive tobacco control program in place at the time. Other states excluded from the analysis had incomplete data. These prevalence rates were adapted from the national Behavioral Risk Factor Surveillance System, conducted by the U.S. Centers for Disease Control. See Hamilton, W., Rodger, C., Chen, X., Njobe, T., Kling, R., Norton, G., "Independent Evaluation of the Massachusetts Tobacco Control Program, Eighth Annual Report: January 1994-June 2001," Abt Associates Inc., chapter 2, p. 30, available at www.mass.gov/dph/mtcp/reports/reports.htm.

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